# Project Research Paper

***A Cross-Provincial Study of Health Care Reform in Canada***

*Grey Literature Review: Synthesis Paper*

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## Introduction

Standing apart from the general academic health policy literature are the multiple systemic studies of the health care system. These system-wide studies have become vastly more numerous in the last two decades both at the provincial/territorial level and at the national level (most recently). The most common of these are the commissions, task forces and advisory committee‟s struck by provincial governments seeking advice on major reforms to provincial health care delivery systems. Less common have been federally commissioned reports and an additional body of grey literature exists in the form of reports or studies produced through non-governmental organizations (IRPP) or through stakeholder groups in the health care field (CMA). Between the mid to late 1980s and the present virtually every province has commissioned a system wide study and sought recommendations for reform.

Clearly these reports serve a political purpose and their frequency can be explained in part as highly visible public policy exercises by governments. This may in part explain why two relatively distinct “waves” of provincial reports can be identified; the first set emerging in the mid to late 1980s and early 1990s amidst economic recession and fiscal restraint and a second

At the same time, in most jurisdictions while there is a renewed commitment to regional authorities more precise lines of accountability and reporting mechanisms are highlighted between regions and central authorities.

This was not the case in Alberta where the emphasis on governance was to increase the autonomy of regional health authorities and diminish that of the central authority to merely that of "primary, but not exclusive source of funding." Even the evaluative role of the Ministry would be diminished relative to that recommended in other jurisdictions.

Among priorities for health system reform health information systems, performance measurement and evidenced-based decision making was a consistently high on the agenda of later health reports. Health information systems and health data management were seen as necessary infrastructure both to the advancement of primary health care (electronic health records) and for long-range strategic planning efforts and resource allocation. Needs-based or population-based funding mechanisms figure prominently in the analyses with an increased desire to fund regional authorities or institutions based on long-range strategic plans and well developed goals and standards based on defined population health needs.

Making the system more accountable for resource allocation decisions is evident in the extent to which all jurisdictions emphasize performance measurement and reporting mechanisms. Without exception, each jurisdiction recommended some form of public reporting mechanism either through annual performance reports by the relevant ministry or department or through the creation of independent councils or commissions charged with assessing overall system performance including outcomes, cost and population health status.

Recruitment and retention of health providers is a consistent theme among all of the reports. The recommendations do not focus so consistently on physician services but are expanded to include recruitment and retention incentives for nurses and other health

## National Reports

(see Tables 3-6)

**Mandates**

While federally driven studies of the national health care system have been relatively few and far between, there have been other studies undertaken by national stakeholder organizations and third party organizations that attempted to evaluate the health care system in terms of its national dimensions. These reports have generally focused on the federal-provincial-territorial relationship in funding publicly insured services and in evaluations of national standards for federal financing. One of the earliest of these studies was undertaken by the Canadian Medical Association in the mid-1980s. The task force established by the CMA was specifically mandated to assess the allocation of health care resources in the face of an increasing elderly population and the explosion of new technology. Population aging and technology were anticipated to be the predominant cost-drivers in a system already troubled by a growing debate about the adequacy of its funding.

The terms of reference for the National Forum on Health were not defined in precise terms. It was mandated to "inform and involve Canadians in seeking out innovative ways to improve the health care system and the health of the Canadian population" but was not asked specifically to assess any particular aspect of the national health system. This contrasts with the later mandates of both the Kirby and Romanow Commissions. The terms of reference for the Standing Senate Committee on Social Affairs, Science and Technology were that it would be authorized to examine and report upon the state of the health care system in Canada. Specifically, the Committee was to examine the fundamental principles on which Canada's publicly funded health care system is based. The Committee would look at the pressures on and constraints of Canada's health care system both financial and systemic. And finally, the Committee would examine the role of the federal government in Canada's health care system and examine the health care systems in foreign jurisdictions for alternate approaches to health care delivery and financing. The focus of the Romanow Commission was even narrower in its mandate by being tasked specifically with an evaluation of the publicly funded health care system, and to recommend policies to ensure over the long term the sustainability of a universally accessible, publicly funded health system.

This increasingly specific focus on the publicly funded system and sustainability was characteristic of other reports as well. The report of the provincial-territorial Ministers of Health was predictably focused on making recommendations for "ensuring the integrity and stability of the publicly funded health system" with special emphasis on the level of federal transfers and the role of the federal government in meeting provincial and territorial health needs. But this was also characteristic of other reports issued by non-governmental and stakeholder groups. As with recommendations contained in both Kirby and Romanow, the Institute for Research on Public Policy‟s task force had focused on sustainability of the national health care system and specifically with addressing the addressing the relationship between federal and provincial governments both in terms of "funding and leadership."

**Focus and observed policy levers**

National studies (See Table 7: National Reports)

term care and mental health services and so on. Contractual relationships with providers and regional health authorities are important instruments of accountability.

# Bibliography

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Québec

# Appendix

(„89) physician services.
Provincial finances threaten the

Absence of system wide goals and targets.
Resources were being used to

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| | demands placed on the system. | | | |

National Reports

Table 7: National Reports

| | Diagnosis |
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| | imposed change at a pace that "cannot be absorbed" by provincial and territorial health systems.<br>The most significant challenge for the system is to maintain universally accessible and quality health services under a public system with fewer resources.<br>Offloading has shifted public costs onto individuals either by de-insuring or introducing user fees.<br>The focus of public funding of medicare is focused excessively on funding hospital and physician services.<br>A major barrier that makes the offloading of costs more attractive than substantive organizational change is the rigid and compartmentalized manner in which services are currently funded, organized and delivered.<br>Decisions related to the health care sector are often not a product of evidence but of the values and interests of decision-makers.<br>The system lacks high quality data to develop the proper mechanisms or protocols, clinical guidelines or care management strategies. | | Pharmacare<br>Primary health care<br>Needs-based funding<br>Non-medical determinants of health (income support, childhood development, etc.)<br>Evidence-based decision-making<br>Health information | Financing (sustain transfer levels)<br>Organizational changes |
| Provincial and | | | | |